MDR Tracking Number: M5-04-2643-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 22, 2004.

Correspondence submitted by ___, revealed Dr.V desires to withdrawal the fee issues. Therefore no further action is required on the fee issues.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, therapeutic exercises, EU & CM-unlisted therapeutic procedures, manual traction, joint mobilization, electrical stimulation-unattended, unlisted procedure, neuromuscular re-education, manual therapy-tech, and chiro manual treatment-spinal were not found to be medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. As the office visits, therapeutic exercises, EU & CM-unlisted therapeutic procedures, manual traction, joint mobilization, electrical stimulation-unattended, unlisted procedure, neuromuscular re-education, manual therapy-tech, and chiro manual treatment-spinal were not found to be medically necessary, reimbursement for dates of service rendered 4/28/03 through 10/21/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

June 28, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2643-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: office notes, physical therapy notes, radiology report and designated doctor exam.
Information provided by Respondent: correspondence and designated doctor report.

Clinical History:
The claimant sustained an injury to this back during the course and scope of his employment on ___. He was provided an extensive course of medical management, advanced invasive pain management services, and physical therapy services from the date of injury through 02/01/03. He changed treating doctors and subsequently received protracted chiropractic services from 03 January through at least 21 October 2003. A required medical examination was determined the worker's compensable back injury was, at most, a soft tissue injury by nature and the worker's condition likely reached maximum medical improvement in no more than 6 months.

Disputed Services:
Office visits, therapeutic exercises, EU & CM-unlisted therapeutic procedures, manual traction, joint mobilization, electrical stimulation-unattended, unlisted procedure, neuromuscular re-education, manual therapy-tech, and chiro manual treatment-spinal,

during the period of 04/28/03 through 10/21/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
The clinical evidence in this file indicates this individual sustained, at most, a soft tissue injury to his back. Current evidence-based medical literature clearly upholds that such injuries are self-limiting and a natural course of healing occurs within 4-8 weeks in the vast majority of such injuries.

Rule 134.500 of the Texas Worker's Compensation Act provides that an injured worker is entitled to all healthcare reasonably required by the nature of his injury as and when needed. These services must be documented as medically necessary services and supported as such by the clinical documentation submitted by the treating doctor. Medical necessity supportive documentation must relate how the recommended services treat the diagnosis, promote recovery from the compensable injury, or enhance the ability of the employee to return to or retain employment. The clinical records submitted by the treating chiropractor did not substantiate the medical necessity of the services in question.

Sincerely,